



Teaching poverty and health: Importing transformative learning into the structures and paradigms of medical education

Santé et pauvreté : introduction de l'apprentissage transformateur dans les structures et les paradigmes de l'éducation médicale

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Article abstract

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Methods: This research drew on qualitative case study methodology and interview data, using the concept of transformative education to direct data analysis and interpretation.

Results: Our findings centred around two broad themes: misalignments between transformative learning and the structures of medical education; and unintended consequences of transformative education within the dominant paradigms of medical education. These misalignments and unintended consequences provided insight into how courses operating within the structures, hierarchies and paradigms of medical education may be limited in their potential to contribute to transformative education.

Conclusions: To be truly transformative, medical education must be willing to try to modify structures that reinforce oppression rather than integrating marginalized persons into educational processes that maintain social inequity.

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Santé et pauvreté: introduction de l'apprentissage transformateur dans les structures et les paradigmes de l'éducation médicale

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Abstract

Background: As a paradigm of education that emphasizes equity and social justice, transformative education aims to improve societal structures by inspiring learners to become agents of social change. In an attempt to contribute to transformative education, the University of Toronto MD program implemented a workshop on poverty and health that included tutors with lived experience of poverty. This research aimed to examine how tutors, as members of a group that faces structural oppression, understood their participation in the workshop.

Methods: This research drew on qualitative case study methodology and interview data, using the concept of transformative education to direct data analysis and interpretation.

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Conclusions: To be truly transformative, medical education must be willing to try to modify structures that reinforce oppression rather than integrating marginalized persons into educational processes that maintain social inequity.

Résumé

Contexte : En tant que paradigme favorisant l'équité et la justice sociale, l'éducation axée sur la transformation vise à améliorer les structures sociétales en inspirant les apprenants à devenir des agents du changement social. Dans une visée d'éducation transformatrice, le programme de doctorat en médecine de l'Université de Toronto a mis en place un atelier sur le thème de la santé et la pauvreté auquel participaient des tuteurs ayant une expérience vécue de la pauvreté. Notre recherche visait à examiner comment les tuteurs, en tant que membres d'un groupe confronté à l'oppression structurelle, ont compris leur participation à l'atelier.

Méthodes : Cette recherche qualitative s'est appuyée sur une méthodologie d'étude de cas et sur des données d'entrevue, en utilisant le concept d'éducation transformatrice comme prisme pour l'analyse et l'interprétation des données.

Résultats : Nos résultats s'articulent autour de deux grands thèmes : les décalages entre l'apprentissage transformateur et les structures de l'éducation médicale, et les conséquences inattendues de l'éducation transformatrice au sein des paradigmes dominants de l'éducation médicale. Ces divergences et ces conséquences non voulues ont permis de constater que les cours qui sont ancrés dans les structures, les hiérarchies et les paradigmes contribueront peu à l'éducation transformatrice.

Conclusions : Pour que l'éducation médicale soit véritablement transformatrice, il faut qu'il y ait une volonté de modifier les structures qui renforcent l'oppression plutôt que de faire entrer les personnes marginalisées dans des processus éducatifs qui perpétuent l'inégalité sociale.

The social determinants of health (SDOH) have received increased attention in medicine and in the training of future physicians over the past two decades.^{1,2} While not a new concept, attention to the SDOH and to the needs of marginalized and vulnerable people has become more formalized within Canadian medical school curricula.^{1,3} However little evidence exists to support the assumption that teaching about the SDOH will lead to future students taking action to achieve greater health equity. Concerns have been raised that traditional methods of teaching about the SDOH may inadvertently perpetuate inequity by framing the SDOH as *natural*, thus maintaining the status quo.³ DasGupta et al.⁴ suggest that the ideas of educational thinker Paulo Freire can provide medical educators with direction for how to reframe traditional hierarchical patterns of learning to consider not only what is taught, but how it is taught as well.

Paulo Freire was a Brazilian philosopher, critical pedagogue, and educator in the latter half of the 20th Century who advocated a paradigm of education that required those facing structural oppression to liberate themselves through a process of humanization.⁵ Structural oppression originates from the injustices that are systematically reproduced within the hierarchical and structural mechanisms of major institutions, including healthcare and education.⁶ Freire believed that education was never neutral and must always be transformative. As a paradigm of education that emphasizes equity and social justice, transformative education aims to improve societal structures by inspiring learners to become agents of change.⁷ Freire proposed that critical, humanizing, and liberating dialogue with persons who are oppressed was the key to structural change.⁵ Rather than being simply a discussion, Freire described dialogical action as a process of liberation that transforms reality through cooperation, communion, and unity amongst oppressors and the oppressed. Within medical education, dialogical learning has been proposed as an instrument for giving expression to voices that are often silenced, marginalized, and disempowered, and for contributing to a transformation of perspective that is humanistic, democratic and critically reflective.⁸ However, it has also been acknowledged that structural barriers to dialogic teaching within institutions of medical education, such as insufficient time, established hierarchies, and the influence of student evaluations on teaching style, may limit its full enactment and realization.⁹

In an attempt to contribute to transformative education, the University of Toronto implemented a three-hour

workshop in 2011 on poverty and health. This workshop was delivered each year to all MD program students during the transition to clerkship. This workshop took place in small groups of 10 students, each with a health professional tutor (usually a physician) and a tutor with lived experience of poverty. During the workshop, the lived experience tutors were interviewed about their experiences of accessing care within the healthcare system. They were also prompted to provide feedback as students were asked to elicit a social history based on several written case presentations. The purpose of including lived experience tutors was to provide students with a deeper understanding of poverty through the tutors' narrative experiences. The workshop aimed to be transformative by drawing attention to issues of equity and social justice through engagement in discussion and dialogue with the lived experience tutor. Four authors of this paper (EI, RG, SG, MH) were involved in curriculum development and facilitation of the workshop and three authors (EI, RG, SG) were principal investigators for a grant that supported this evaluation research. One author (DH), who plays an active role in developing clinical and health education curricula to avoid stigmatization, coached lived experience tutors in shaping their stories to reflect the lesson plan, and debriefed with them after the workshop sessions. Two education scientists (CW, SW) and a research assistant with experience in health professions education research (CC) contributed a more distanced and critical perspective in analysing the study data.

While the goals of the workshop were transformative, we realize that the workshop took place within the boundaries of medical education, which is heavily influenced by behaviourist and cognitive paradigms of education and hierarchical structures of power.⁷ This paper provides an overview of our critically reflexive evaluation process in which we studied how the taken-for-granted structures either facilitated or limited the impact of transformative approaches to education. In the spirit of Freire, we felt it was crucial to move beyond an exploration of the transformative impact of the workshop from the students' perspective: we gave some attention to how students experienced the involvement of the tutors with lived experience of poverty; however, we focused primarily on how the tutors with lived experiences of poverty, as members of a group that faces structural oppression, understood their participation in the workshop.

Methods

Study setting and design

This study focused on a single *Poverty and Health* workshop that has been delivered over the past nine years. It drew on qualitative case study methodology to understand the experience of lived experience tutors and students in a workshop on poverty and health within the context of an undergraduate medical education curriculum. This case study was both descriptive and instrumental.^{10,11} We wanted to both describe how lived experience tutors perceived their involvement in this workshop as well as how students perceived the value and contributions of these tutors. This case study was constructionist in that it was built from the subjective stories of participants and through the researchers' interpretation of these shared experiences,¹⁰ while drawing on the theoretical concepts of Paulo Freire.⁵

Sampling size and sampling methods

We interrogated this case through the collection of data from several sources. Five semi-structured interviews with lived experience tutors and five semi-structured interviews with undergraduate medical students made up our primary data set. Participants were selected conveniently and purposively: students from the most recent cohort (of approximately 250) that expressed interest in participating were recruited by RG, SG and EI and interviewed in 2019; Tutors with lived experience of poverty were recruited by one author (DH) with knowledge of the availability of the individuals who had tutored in the workshop since 2011 (with approximately 20 tutoring each year, some new and many returning). All interviews were conducted in 2019. Tutors were selected in order to obtain a breadth of experiences from long-standing experienced tutors with significant expertise, as well as those who were newer to tutoring. Student participants were remunerated with a nominal gift card, while lived experience tutors were remunerated with a nominal monetary amount to acknowledge their time and contributions to the research. A research assistant (CC) conducted the interviews with both students and tutors with lived experience of poverty. These two sets of interviews were different in focus: interviews with lived experience tutors specifically probed their experiences as tutors in the workshop; interviews with students had a broader scope, asking about many aspects of the workshop, including the involvement of lived experience tutors. The analysis described in this paper emphasizes the involvement of the lived experience tutors rather than the workshop more broadly. We also used the

workshop tutor guide as a point of comparison in looking for consistencies and discrepancies between the formal syllabus and the information that was gathered from interviews. Given the richness of the dataset and the triangulation between student, tutor, and course syllabus data, we believe that our study has strong information power, despite including a small number of participants.¹²

Data analysis

We used qualitative thematic analysis to code and interpret the interview data. Thematic analysis is a flexible tool and an approach that seeks to identify patterns within qualitative data.^{13,14} Five team members contributed to a first round of open coding. Four members of the team independently coded two transcripts each, while a research assistant independently coded each of the ten transcripts. The research assistant met with each of the other team members to review each independently coded transcript and come to agreement on the coding. This coding involved searching for recurrent and direct statements by participants about their experiences in the workshop. The research assistant engaged in a second round of higher-level coding by drawing on the concepts of Paulo Freire⁵ to reconstruct and make sense of the themes that had been agreed upon in the first round of coding.

This study was approved by the University of Toronto Research Ethics Board and written informed consent was obtained from all research participants.

Results

During interviews, lived experience tutors described deeply personal, traumatic, and stigmatizing experiences of accessing healthcare while living in poverty, which they also shared during the workshop. These experiences were complex and most described connections to poverty through membership in socially marginalized groups experiencing mental health concerns, substance use, homelessness, joblessness, intimate partner violence, and racialization. Overall, lived experience tutors described positive interactions with both health professional tutors and workshop students, describing respectful, thoughtful, and compassionate responses to their contributions. Despite these positive experiences, interviews with lived experience tutors and workshop students drew attention to 1) misalignments between the transformative intentions of the workshop and the structures of medical education, and 2) unintended consequences of transformative learning within the dominant paradigms of medical education.

Misalignments between the goals of transformative education and the structures of medical education

Despite involvement as *tutors* in the workshop, both lived experience tutors and students perceived traditional roles and hierarchies inherent within medical education. These hierarchies may have been exacerbated by a deficiency in feedback being provided to tutors as well as by the brief nature of the workshop on poverty. In the formal workshop material both the health professional and the lived experience contributors were referred to as *tutors*, suggesting a strategic attempt to place the lived experience and the health professional tutors on a level playing field. One lived experience tutor even remarked that the health professional tutor (a physician) “*treated me like I was her equal*” [tutor 005]. Some lived experience tutors described taking on the role of a teacher, recognizing that they had valuable information to share with students:

I'm going to leave you with something about me, because I am a recovering addict, a survivor of husband abuse, a survivor of mental health and homelessness and poverty, and today I teach doctors. [tutor 003]

I kind of find it more like [the students] look upon me as like I'm a teacher almost. Like, direct questions, hands up, that kind of thing [...] ask me anything you want and I'll answer them if I can or to the best of my knowledge or my experience or what I would like to see. [tutor 005]

Others, however, did not share in this identification with the role of a teacher. Despite having significant knowledge about poverty and related social contexts, some tutors did not perceive themselves as having expertise:

In terms of teaching methods, it felt mostly just like an open discussion. There were moments where the teacher was doing their job, I guess, and educating them. I don't know. I've never even been to school, so I don't actually know any [teaching methods]. [...] And also not in academics, I don't even know ... I can't even fathom what would make sense, living in that world. [tutor 002]

Despite playing an active role in the teaching process, several tutors described that the health professional tutor held more legitimacy in the classroom. This was a preconceived expectation of the lived experience tutors:

Well, the co-facilitators always pretty much determine the direction and I would absolutely be deferential,

because I am deferential to the co-facilitator [...] to a certain degree. That, I think, also goes to our ingrained respect of doctors' knowledge. [tutor 001]

It was also something that was perceived and solidified through the experience of attending the workshop:

[The students] probably have more respect, I think, to be honest, for a doctor than someone who is a lived experience person just because they're going to become what this person has been for x amount of years. [tutor 004]

Student participants also perceived a hierarchy in which the lived experience tutors were not considered equals with the health professional tutors; for example, student participants referred to the lived experience tutors as the “*patient*” [student 103] or “*volunteer*” [student 104] during interviews.

Through the interviews, it was revealed that there were aspects of the course structure that may have contributed to this perception. For example, lived experience tutors described variable amounts of engagement with the health professional tutors in advance of the workshop, with only one lived experience tutor meeting with the health professional tutor beforehand. Furthermore, none of the lived experience tutors described having been provided with formal feedback or evaluation of their tutoring, which perhaps created further distance from a traditional teaching role where this would be expected. When prompted, one lived experience tutor provided specific examples of feedback she would value receiving:

Well, how did I come off to them? Did I give them good enough knowledge? Was I clear and precise? Is there any questions that they felt that they could have asked me? Did I come across intimidating or not? Those kind of things. Do they feel that it would be easy to talk to me? [...] That kind of thing. Yeah, that would be good. Because, we don't see ourselves, right? I'd love to see myself, because what I think I'm doing I may not be doing or what I think is good maybe it could be a little bit overbearing or maybe not enough. So, it would be great to know. [tutor 005]

In the same vein, lived experience tutors also felt that their contributions could be more meaningful or impactful if students had additional interactive opportunities that involved connecting with people experiencing poverty:

It's like basically a few hours in total the thing that we did. I don't know if it's enough time to actually break

*stereotypes or impactful enough to break stereotypes.
[tutor 004]*

In summary, despite efforts to place the health professional and lived experience tutors on equal footing, both students and tutors perceived the traditional classroom hierarchy in which the health professional tutor, often a physician, held legitimacy and power. Structural factors may have contributed to this perception, including insufficient time for meeting between co-tutors, lack of feedback for lived experience tutors, and inadequate opportunities for lived experience tutors to contribute ideas for course improvement. Attending to these structural obstacles may present an opportunity to alter established hierarchies and provide more meaningful roles for lived experience tutors.

Unintended consequences of transformative education operating within the dominant paradigms of medical education

Attempts to implement a workshop that aimed to be transformative may at times have had unintended consequences as it was incongruous with the dominant paradigms of medical education. These unintended consequences included the potential for increased stigmatization of those living in poverty, conflicting messages and overvaluing of traditional information dense teaching over lived experience, understandings of poverty that aligned with the pre-established curriculum instead of lived experience, and sympathizing with oppressive healthcare structures. Despite best efforts to break down stereotypes and stigma surrounding poverty, some participants described situations in the workshop that may have inadvertently perpetuated stigmatization of people experiencing poverty. Several lived experience tutors described variable engagement of the students in the classroom. One tutor described a “polite” [tutor 004] reception from the students. Another described a more hostile reception:

Well, the last one that we did [...] there was a couple of girls that were in our group, [...] but, they were, again, I don't really know how to use the word. I can see their faces. I don't know if it was they're kind of not believing or maybe, like, there was some whispering going on, there was some laughing going on, there was some 'yeah right' going on. That kind of thing. I don't know what's the right word to use for that. But, you know what, I just shrug that off... [tutor 005]

Despite concerted efforts by the health professional tutor to create a respectful environment, these efforts were not always successful. This raises concerns about how a workshop that aims to be transformative in nature can truly meet this objective when participants from marginalized groups do not always feel valued, may be exposed to relational forms of microaggression, and at times have an audience to witness the dismissiveness of others.

One student drew attention to how discrepancies between the teaching by the health professional tutor and contributions of the lived experience tutor led to conflicting messages:

I had my reservations about [the involvement of the lived experience tutors]. [...] I found that, to be honest, it reaffirmed some ideas that some already had. For example, when we were trying to interview her and after, 'how do you feel about this, how do you feel about this'? She was like, 'well it's all fine but I don't need you to point me to resources because that just makes me feel bad about myself.' That was in stark contrast to what the point of the session was, which was to help patients find resources. So, as long as you take everything with a grain of salt and you realise that one patient's experience isn't what they all experience, that's important. [...] I remember not enjoying that part of it because I had learned so much and then hearing the [lived experience] co-facilitator's experience being so opposite of my expectancy to use all of these resources. I was like, okay I don't think I'm ever going to use this, that was a waste of the session, what if that would irritate every single patient I meet, I'll avoid them. [student 104]

This student apparently expected to receive information from the lived experience tutor that aligned with the information that a more traditional and information-giving style of learning had provided. While this discrepancy contributed to further understanding that individual patients had unique experiences, it also created unwanted confusion about what the correct response to poverty should be.

In addition to sharing their personal stories and experiences, lived experience tutors were also asked during the workshop to comment and answer questions as several case studies were presented. The case studies described several members of a family, and focused on the mother, whose social history included immigrating to

Canada as a child, never completing high school, and relying on a family income of \$1800/month from a warehouse job. The case studies were intentionally designed to help students see that poverty does not always fit with our pre-determined assumptions or *look a certain way*. One lived experience tutor commented that:

The scenario was mostly about a woman and her child that came from another country, they still lived in a place, that kind of thing [...] I think there needs to be a lot more emphasis on more vulnerable sectors. [tutor 005]

Although lived experience tutors were asked to draw on their own expertise and experience of poverty to comment on the case studies, several did not seem to relate to the case studies that were presented.

In addition, while most lived experience tutors described traumatic experiences within the healthcare system, participation in this workshop played a role in informing them about the realities of the health care system within which physicians train and work:

Yes, it's definitely made me be more compassionate with my GP, and they're also people which was my takeaway. It's still frustrating, but it made me realize, though, it's not that they're like a shitty healthcare provider, it's that they're doing their job, and their job comes with time constraints. [tutor 002]

Inadvertent exposure to indifferent or hostile attitudes from students may have jeopardized the transformative value of the workshop. Being asked to comment on case scenarios that didn't necessarily reflect their own lived experience left tutors feeling as though their own realities had not been captured. This may have been exacerbated by the expectations of some students for unambiguous, objective, and universal solutions for addressing poverty, which aligned more with the dominant structures and paradigms of medical education than with the lived realities of those living in poverty.

Discussion

Paulo Freire proposed a solution to oppression through the transformation of social structures, rather than through the integration of the oppressed into the existing structures of domination.⁵ Our findings offer insight into the challenges of offering a course that aims to be transformative within the dominant structures and paradigms of medical education. As a field, medical education operates within an order of established

hierarchies, in which institutional culture favours those in positions of power. Our findings reveal the importance of attending to the larger structures of medical education if we desire specific courses to be successful in achieving their transformative aspirations. This case study further serves as an exercise in critical reflexivity in which we seek to challenge our own beliefs and assumptions and recognize that they have been formed within the existing structures of medical education.¹⁵ While our research findings are limited by a small sample size and applicability to a single workshop within the specific context of undergraduate medical training, we believe that the findings can be of value for other training programs that draw on individuals with lived experience to contribute to the education of health professionals.

Our findings raise questions about *who does* and *who should* qualify as being a legitimate teacher within the field of medical education. Within educational environments, academic credentials serve as a form of currency. This reliance on degrees and credentials as proof of legitimacy excludes members from some groups, such as lived experience tutors, from having authority in the classroom. Lived experience tutors highlighted how opportunities for meeting with the health professional tutor ahead of time and being provided with feedback might contribute to their reconceptualization as important members of the teaching team. These are simple and practical additions that medical programs could make to signal the importance of lived experience as a source of legitimate knowledge. As a three-hour session, both students and lived experience tutors understood the limitations for how deeply and broadly the complex topic of poverty and health could be explored. Solving this dilemma may require program leaders to think critically about how issues of poverty and the social determinants of health might be distributed across both the curriculum and across non-classroom settings that are more familiar to those with experiences of poverty. Failure to address these barriers to legitimacy may perpetuate a hidden curriculum of undervaluing humanistic values. While a great amount of literature has been published on efforts to address the hidden curriculum through interventions that target individual medical students and faculty, less attention has been given to how organizations and institutions themselves might be reformed in order to avoid contributing to problematic practices.¹⁶

The preferential valuing of the health professional tutor and information dense modes of learning also challenges whether diverse epistemologies and ways of knowing are

truly accepted within the field of medical education. Incorporation of diverse forms of knowledge is central to education that aims to address issues of culture, justice, and power.¹⁷ This workshop on poverty and health presented an opportunity to integrate a more experiential and dialogic way of understanding. Despite this opportunity, there was still a tension for some learners between the experiential and contextual expertise of the lived experience tutors and the *hard facts* or protocols of *what to do*. As such, lived experience tutors entered a situation in which an information-giving style of teaching was valued and an opportunity to reconceptualize legitimate ways of knowing in medical education (i.e., through valuing the experience and knowledge that lived experience tutors could bring) was potentially missed.

While most lived experience tutors described positive experiences in the workshop, they also described responses that may unintentionally perpetuate social class structures. The case studies depicted poverty in a way that many of the lived experience tutors could themselves not relate to. The dilemma of patient representation in medical education has been elaborated previously, with concerns about how recruitment of white, affluent, older adults may unintentionally reproduce structures of power and privilege by silencing voices of those from less privileged social groups.¹⁸ We believe that the inclusion in this workshop of individuals from highly marginalized groups was a powerful and symbolic representation of poverty with the potential to inform critical thinking, humanism, compassion and empathy, without any aims of objectivity or generalizability.¹⁸ Future scholarship might explore how representations of poverty impact physician trainees' understanding of privilege and power. It was not clear from our research whether drawing attention to common experiences of poverty in the case studies inadvertently minimized the social distance between those living in poverty and the future privileged positions of physicians in training. We wonder whether these representations may contribute to limited engagement with issues of privilege and power that are imperative for any program that aims to train future physicians to actively address problematic social structures and inequities.

Unexpectedly, through this workshop, many of the lived experience tutors reported learning about the constraints on clinicians, recognizing that short clinical appointments limit the capacity for health care providers to be humanistic, empathetic, and person-centred. Rather than making suggestions for how clinical care settings might be

altered, lived experience tutors adopted a compassionate stance towards physician learners and providers. In effect, they themselves sympathized with a model of care that had been personally traumatic for many of them. As a consequence, this may have drawn attention away from the role of future physicians in implementing structural change within healthcare settings to make care more humanistic and person-centred.

Conclusion

As social values and societal norms change, it is crucial that stakeholders in the field of medical education continue to be reflexive and consider how the field can continue to change in ways that are oriented towards social justice. While the workshop on poverty and health explicitly included content and methodologies that addressed social injustice and inequity, it had to do so within the hierarchical structures and paradigms of medical education. While it would be unreasonable to expect medical students, after several years of training, to suddenly recognize lived experience tutors as *teachers* and their experiences of poverty as *learning*, it is vital that we consider ways to make the implicit, explicit, and the normal, strange.¹⁹

Adopting a Freirian lens to critically evaluate this workshop on poverty and health was a strength of this evaluative research, as it allowed us to be reflexive about the role that tutors with lived experience of poverty were playing within the structures and paradigms of medical education. Despite best efforts to introduce transformative education into the medical curriculum, the structures and paradigms of medical education inhibited this intention. The workshop was successful at integrating marginalized persons into current structures and paradigms of medical education. However, to be truly transformative, the power of the voices of marginalized persons must be recognized, especially within current hierarchical structures. Their experiences must be as highly valued as traditional paradigms of education, and their experiences must be adequately represented in course curricula and syllabi.

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Authorship: CW, SG, RG, EI, MH, DH and SW conceptualized and designed this project. CC was responsible for data acquisition. All authors took part in data analysis and interpretation. CC, CW and SW drafted this manuscript. SG, RG, EI, MH and DH critically reviewed and revised the manuscript for important intellectual content. All authors approved the final submitted version of the manuscript. All individuals who qualify for authorship based on ICMJE criteria have been listed as authors.

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